

Commonwealth Of Kentucky

Health Insurance/Flexible Spending Application

(for Use By Agencies in the State Payroll System - UPPS)

Reason for Application

☐ < New Employee ☐ < New Group ☐ < COBRA ☐ < FSA Only ☐ < Other
☐ < Open Enrollment ☐ < Move Out of Service Area* ☐ < Previously Waived**

* If Moving Out of the Service Area, enter the Qualifying Event Date: _____

** If you Previously Waived, enter the Qualifying Event Date AND a description of the Qualifying Event: _____ Date _____ Description _____

MUST BE COMPLETED BY THE INSURANCE COORDINATOR

Insurance Effective Date			Company Number		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home County		Work County		Contiguous County	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> < Dual Employee Code					

SECTION I: DEMOGRAPHIC INFORMATION

PLEASE PRINT

SSN

Date of Birth / /
Month Day Year

Name (First, MI, Last)

Gender Marital Status

☐ < Male ☐ < Married
☐ < Female ☐ < Single

Street Address

PO Box / Apt. #

City, State, Zip Code

County of Residence

Country/Mail Code -- If NOT U.S.A.

Hire Date

Employer Name

Policyholder's Daytime Phone Number

SECTION II: PLAN SELECTION

1. County of Coverage

Check only one

☐ < Home
☐ < Work
☐ < Contiguous

Name of County of Coverage

2. Plan Code

If waiving coverage,
enter 999 and go to
Section VI.

3. Option

☐ < A
☐ < B

4. Level of Coverage

☐ < Single
☐ < Parent Plus
☐ < Couple
☐ < Family

5. Payment

☐ < Monthly
☐ < Twice Monthly

If none selected, you will
be set up for Twice Monthly

6. Cross-Reference ***

☐ < Yes
See below table
in Section IV

7. PCP Selection

PCP# -- If required by Carrier

Are you a current patient? Yes ☐ No ☐

SECTION III: PRIOR HEALTH COVERAGE

Have you, or any eligible dependent, been covered by a health insurance plan during the twelve months prior to this coverage going into effect? Yes ☐ No ☐

If yes, provide the following information. This information will be used to determine waiting periods for pre-existing conditions.

Type of Coverage: ☐ < Group ☐ < Individual ☐ < COBRA ☐ < Medicare ☐ < Medicaid

Level of Coverage: ☐ < Single ☐ < Parent Plus ☐ < Couple ☐ < Family

Insurance Company Name

Name of Employer Providing Coverage (If group policy)

Effective Date

Termination Date

SECTION IV: SPOUSE AND/OR DEPENDENT INFORMATION

Social Security Number	Name (First, MI, Last)	Gender <i>Circle One</i>	Date Of Birth (MM/DD/YYYY)	Rel. Code	PCP # (If required)	Current Patient? <i>Circle One</i>
		M F				Y N
		M F				Y N
		M F				Y N
		M F				Y N
		M F				Y N

***TO BE COMPLETED BY THE SPOUSE'S INSURANCE COORDINATOR (Only needed if this is a Cross-Reference application):

Spouse's Company
Number (REQUIRED) -->

Spouse's Dual Employee
Indicator, if applicable -->

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